



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEJAS ANESTHESIA PA
SUITE 3100
4242 MEDICAL DRIVE
SAN ANTONIO TX 78229

Respondent Name

Texas Mutual Insurance Company

Carrier's Austin Representative

Box Number 54

MFDR Tracking Number

M4-09-9489-01

MFDR Date Received

June 18, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are no longer contracted with Aetna WC effective 01/01/09. Therefore our charges should be paid accordingly: 11.7 units x \$53.68 = \$628.06 allowed."

Amount in Dispute: \$296.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual's claims paying system reduced the amount of reimbursement of the treatment rendered by Stephen F. Rabke, M.D., due to participation in a PPO network through Focus/Aetna Workers Access LLC."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 15, 2009	01630-AA	\$296.47	\$296.47

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.4 sets out the Written Notification to Health Care Providers of Contractual Agreements for Informal and Voluntary Networks.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- CAC-45 – Charges exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 793 – Reduction due to PPO contract
- CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration
- 891 – The insurance company is reducing or denying payment after reconsideration

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the insurance carrier issue payment for CPT code 01630-AA pursuant to 28 Texas Administrative Code §134.203?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "CAC-45 – Charges exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement" and "793 – Reduction due to PPO contract." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 22, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

A review of the submitted medical bill finds that the requestor billed CPT code 01630 defined as "Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified." The requestor appended modifier -AA defines as "anesthesia services performed personally by anesthesiologist."

A review of the submitted medical documentation supports that the requestor rendered the services as billed. As a result, reimbursement is determined pursuant to 28 Texas Administrative Code §134.203 (c).

3. Per 28 Texas Administrative Code §134.203 (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

The Division reviewed the submitted CMS-1500 (bill) and finds that the anesthesia was started at 8:25 and ended at 10:06, for a total time of 101 minutes.

Per CMS one anesthesia time unit = 15 minutes of anesthesia time. The 15-minute time interval will be divided into the total time indicated on the claim. Total time should always be accurately reported in minutes. Actual time units will be paid; no rounding will be done up to the next whole number – only round to the next tenth. Therefore, the requestor has supported $101/15 = 6.73$.

To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance.

The Anesthesia Base Units for CPT code 01630 is 05; the 2009 DWC Conversion Factor is \$53.68.

The MAR for CPT code 01630-AA is: (Base Unit of 5 + Time Unit of 6.73) 11.73 X \$53.68 DWC conversion factor = \$629.67. The insurance carrier issued payment in the amount of \$331.59, minus the MAR amount of \$629.67 equals a reimbursement in the amount of \$298.08. The requestor seeks additional reimbursement in the amount of \$296.47, therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$296.47.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$296.47 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	October 31, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.